ordered patient specific billable services such as medical supplies charged to patients, respiratory therapy, physical and occupational therapy. Allowable costs are necessary and ordinary operating expenses including capital and insurance costs.

The base year operating expenses less base year capital are inflated by the indices described in Section III. Principal payments on debt are not included in capital costs. Base year capital is tested for reasonableness by comparing projected changes in capital expenditures and calculated using the greater of actual patient days or 85 percent of available licensed capacity days.

BASE YEAR

These methods and standards are revised to provide for a rebasing of costs incorporated into the rate calculation process for facilities with prospective fiscal years beginning January 1, 1997 through December 1, 1997. Base year and approved year financial and statistical information will be identical in rate calculations for facilities with fiscal years beginning during that time.

The reasonableness test is applied to not allow the rolling base year to unduly reward or penalize the providers. For example, the allowable costs per patient day (base) are subjected to a test of reasonableness where the 1994 base plus inflation is compared to the 1996 approved rate. For providers who maintain costs at a level less than the base plus inflation, the provider will be allowed to retain 50% of the savings up to 5% of the base. For the providers who have not maintained costs within the approved 1996 rate when inflation is added to the base, the provider will be able to keep only 50% of the difference not to exceed 5% of the base.

Allowable costs for routine services per day less capital as calculated in the base year are adjusted to reflect inflation between 1994 and 1996. This cost per day is compared to the approved cost per day in the 1996 year. The following adjustments are made:

1. If the base year costs exceed the approved costs, the allowable costs for 1997 will be limited to the 1996 approved costs plus the inflation between 1996 and 1997 plus 50% of the difference between the allowable costs of the two years limited to 5% of the costs in the 1994 base year.

2. If the base year costs are less than the approved costs, the routine service costs will be calculated using the 1994 allowable base costs plus inflation identified in the inflation section plus 50% of the difference between the two years limited to 5% of the costs in the 1994 base year.

Ancillary costs are built into the single calculated per diem rate. Actual ancillary costs are calculated from the 1994 base year costs less long-term care prescription drug costs. The costs are separated between base year capital and noncapital allowable costs. Inflation is added to the non-capital costs.

Ancillary and routine capital costs in the rate year are allowable facility base year capital costs, plus Department determined capital costs on CON approved capital additions which are placed in service after the beginning of the base year and before the end of the rate year.

A 1997 example of the calculation of allowable routine costs for a January 1 facility is as follows:

		1994 BASE	1996 APPROVED
Operating Expenses		$2,707,182	$2,861,358
Inflation on Base Year 1994-1996		124,503	
Total		$2,831,685	$2,861,358
Units of Measure		13,803	13,949
Rate per patient day		$205.15	$205.15
Total		$205.15	$205.15
Difference (Base-Current)	(0.00)		
50% of Difference	0.00		
5% of Base	$9.81		
If Difference is Negative:			
Add 6.6% Inflation to Base		12.95	
Plus 50% or 5% whichever is less		0.00	
If Difference is Positive:			
Add 1.90% Inflation to Approved			
Plus 50% or 5% whichever is less			
1997 Allowable Routine Rate Per Patient Day		$209.08	

For FY 1997 each facility will be rolling off of their base year of 1994. For fiscal years after 1997 this calculation will be utilized to determine if the base year allowable routine rate will be based on the approved or the base year actuals. The determination process is outlined in **BASE YEAR** explanation.

The example for routine costs outlines the rate process where the 1994 base year costs equal the 1996 approved costs. The 4.6% inflation factor represents the Commission approved inflation between 1994 and 1996 for January 1 facilities. The 4.6% inflation is

added to the 1994 routine costs per patient day for comparison to the 1996 approved rate per patient day. (The rate is adjusted by 50% of the difference between the 1994 rate and the 1996 rate not to exceed 5% of the 1994 rate.) In the example shown, 5% of the base is greater than 50% of the difference. Therefore, the 5% factor is used.

Calculation of Actual Allowable Ancillary Costs Per Patient Day 1997 rate example:

LONG-TERM CARE

Base Expenses	$156,443
Inflation (6.60%)	10,325
Total Allowable Base Expenses for 1997	$166,768
$166,768 divided by 12,472 equals	$ 13.37

Ancillary costs are calculated by inflating the 1994 actual Medicaid ancillary allowable costs less base year capital per patient day by the inflation factor identified in Section III. This Medicaid ancillary cost is divided by the Medicaid patient days from the 1994 base year.

The actual allowable ancillary costs are related to Medicaid patients only. The base year actual allowable costs are arrived at by dividing the lower of cost or charges into the allowable costs and then multiplying by Medicaid ancillary revenue. Allowable ancillary costs are limited to allowable Medicaid ancillary charges, which are reported by the facilities on the Medicare Cost Report worksheet D. The worksheet D ties to the facilities working trial balance as the amount charged to their Medicaid patients.

For the entire period, the total allowable Medicaid costs in the base year are then divided by the base year Medicaid patient days. For rates established on or after July 1, 1990, the cost of prescription drugs is not included as an ancillary cost. Prescription drug costs and charges are removed from the calculation of actual allowable ancillary costs through information provided by the individual facility, or if not available from the individual facility, from a sample of information submitted from other facilities.

Capital acquisitions not subject to CON approval and obtained after the base year are not included in the budgeted portion of rate year capital costs.

For the calculation of rate year capital costs, projected capital costs for post base year CON approved additions are included in the rate year during the first 3 rate years of asset use if the CON addition is estimated to be placed in service during or before the rate year.

No projected costs are added to the rate year capital for post base year acquisitions not subject to a CON. No costs are allowed for additions pending CON approval or for capital for which a CON was required and not obtained.

Newly constructed facilities shall have the rate set for the first three years at the Alaska Medicaid swing bed rate in effect at the start of the facility's rate year less the average capital costs contained in the swing bed rate plus the appropriate inflation factor. Capital costs identified by the facility are added to the rate using the greater of the occupancy rate approved in the certificate of need or assuming an 80% occupancy rate.

If a facility is granted a Certificate of Need to construct additional beds, the overall facility base year occupancy statistics will be adjusted for the first three rate years during which the additional beds are available for occupancy to reflect 50 percent of the base year occupancy for the additional beds.

V. Sale of Facilities:

For facilities acquired on or after October 1, 1985, the increase in the depreciable base is limited to one-half of the percentage increase since the date of the sellers acquisition, in the Dodge Construction Systems Costs Index for Nursing Homes, or, one-half of the percentage increase in the consumer price index for all urban consumers, whichever is less. All related operating costs including interest are limited to the allowable changes in asset base. No facilities were sold or acquired between 1982 and October 1, 1985 or subsequent to October 1, 1985.

In addition, the recapture of depreciation expense on disposition of assets that accommodate gains under the Medicaid program will be limited by the provisions of 42 CFR 447.253(d) of the Code. Payment for acquisition costs associated with buying and selling of the facility will be limited by the provisions of 42 CFR 447.253 (d) of the Code.

Example of Purchase Limitations

Historical Costs

Book Value	$5,000,000
Accumulated Depreciation	2,500,000
Net Book Value	$2,500,000
Annual Depreciation	$ 200,000
Long-term Debt	$1,000,000
Interest on Debt	$ 100,000
Allowable Costs	$ 300,000
Purchase Price	$8,000,000
Depreciation	$ 400,000
Long-term Debt	$6,000,000
Interest on Debt	$ 600,000
Operating Costs	$1,000,000

Change in CPI (Since original acquisition)	25%
Dodge Index	35%

Allowable change 25% divided by 2 = 12.5%

New Depreciable Base	$5,600,000
Accumulated Depreciation	2,800,000
Net Value	$2,800,000
Depreciation	$ 224,000
Allowable Interest Based on 40% debt prior to purchase on net value at historical 10% rate ($2,800,000 X 40% X 10%)	$ 112,000
Allowable Costs	$ 336,000

Note: The example is simplified for presentation. Original investment was assumed to be made at one time. There are no loan costs or start up costs factored in the original purchase or subsequent purchase.

VI. Year End Conformance:

Facilities with fiscal years beginning January 1, 1997 through December 1, 1997 will not have a Year End Conformance applied.

For fiscal years beginning January 1, 1998 and later, year end conformance will be reviewed for each facility. Approved ancillary rates for the fiscal year ended 24 months before the beginning of the rate year will be compared to the actual ancillary cost per patient day for that period. An adjustment to the prospective rate will be calculated as 90 percent of the difference between the approved ancillary rate and the actual ancillary cost per patient day. If actual total facility costs per day are less than two percent above or below the approved total rate (without year end conformance in the base year rate, if any) no adjustment will be made. A positive adjustment will be limited to the amount that actual total facility costs exceeded the overall approved total rate (without year end conformance in the base year rate, if any) in the base year, and a negative adjustment will be limited to the amount that the approved total rate (without year end conformance in the base year rate, if any) in the base year exceeded the actual total facility costs in the base year.

The Department will, in its discretion, waive all or part of the year end conformance if the facility provides justification that manifest injustice will result if year-end conformance is strictly applied, based upon consideration of the following factors:

- whether the facility has taken effective measures to control costs in response to the situation upon which the waiver request is based.

- whether the waiver request contradict a prior action of the Department as to an element of the facility's rate.

- whether the waiver would result in payment for only allowable cost of services authorized by the division of medical assistance under state or federal laws.

- whether the situation upon which the waiver request is based results from the provision of direct patient care or from prudent management actions improving the financial viability of the facility to provide patient care.

VII. Adjustment to Rates:

Rates for facilities are set by the Department with the advice of five Governor appointed Commissioners. The Commissioners represent the state of Alaska, the providers, a physician, a certified public accountant and a consumer. Facilities have the opportunity to provide additional information on significant changes that would impact the rates.

The Department, on its own or at the request of an applicant, in its discretion, will reconsider its actions within 30 days. There is nothing to preclude a facility from petitioning the Department at any time during its fiscal year for additional consideration.

Reconsiderations are warranted only in those cases where the proper application of the methods and standards described in Attachment 4.19-D is in question or is being challenged.

VIII. Provider Appeals:

If a party feels aggrieved as a result of the Department's rate setting decisions, the party may appeal and request reconsideration or an administrative hearing.

Administrative hearings are conducted by Governor appointed Hearing Officers. An administrative appeal must be filed within 30 days of the mailing of the decision of the Department.

The Hearing Officer would hear a case in accordance with administrative law in the state of Alaska. The Hearing Officer would prepare draft findings, conclusions and order for the Commissioner of the Department's review. The Commissioner of the Department would review the findings of the Hearing Officer and may accept, reject, or modify the Hearing Officer's recommendations. If the party still feels aggrieved at this point, judicial review is available to contest actions of the Department and the rate set.

IX. Audit Function:

The Department has statutory authority to audit data relating to Medicaid prospective payment rates. Audit findings that would affect prospective payment rates are adopted by the Department and incorporated into future prospective rate calculations.

X. Exceptional Relief to Rate Setting:

If the rate setting methodology results in a permanent rate which does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the Deputy Commissioner of the Department for exceptional relief from the rate setting methodology.

This provision applies to situations where a facility is forced to close or dramatically reduce quality of care to its residents due to the inadequacy of its payment rate. To apply for exceptional relief, the facility's application should include:

1. the amount by which the facility estimates that the rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;

2. the reasons why and the need for exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate setting process;

3. the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;

4. the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;

5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;

6. an analysis of community needs for the service on which the exception request is based;

7. a detailed analysis of the options of the facility if the exception is denied;

8. a plan for future action to respond to the problem; and

9. any other information requested by the Deputy Commissioner to evaluate the request.

The Deputy Commissioner may request recommendations from the Commission on a facility's application for exceptional relief. The Deputy Commissioner may increase the rate, by all or part of the facility's request if the Deputy Commissioner finds by clear and convincing evidence that the rate established under Section IV. and Section VI. of Attachment 4.19-D does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest. In determining whether the exception is in the public interest, the Deputy Commissioner may consider at least:

1. the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;

2. the assessment of continued need for this facility's services in the community;

3. whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;

4. the recommendations, if any, from the Commission;

5. the availability of other resources available to the facility to respond to the crisis;

6. whether the relief should have been obtained under the existing rate methodology;

7. other factors relevant to assess reasonable access to quality patient care provided by an efficiently and economically managed facility.

The Deputy Commissioner may impose conditions on the receipt of exceptional relief including, but not limited to the following:

1. the facility sharing the cost of the rate exception granted;

2. the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;

3. the facility providing documentation as specified of the continued need for the exception; or

4. a maximum amount of exceptional relief to be granted to the facility under this section.

If the Deputy Commissioner finds by clear and convincing evidence that the rate established under the methodology does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest, the Deputy Commissioner may, in his or her sole discretion increase the rate.

Amounts granted as exceptional relief shall not be included as part of the base on which future prospective rates are determined. Exceptional relief shall be effective prospectively from the date of the exceptional relief decision and for a period of time not to extend beyond the facility's rate setting year. A facility may apply for and be granted exceptional relief in the following year. A party aggrieved by a decision of the Deputy Commissioner concerning exceptional relief may request an administrative hearing to the Commissioner of the Department.